

## What Ails Behavioral Health Care?

Diagnosis and Treatment Ensure a Healthier Bottom Line for Employer-Sponsored Programs

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**The responses from more than 400 organizations to Buck Consultants' 2005 National Health Care Strategy Survey confirmed that employers are more concerned about health care costs than about any other business cost, and are even more worried about future rather than current health care costs.**

Employers' responses also indicate that they believe that creating greater integration among all elements of the health care delivery system will be an effective way to control costs in the future.<sup>1</sup> To that end, employers have taken the lead in the area of quality improvement in health care. Among other things, they advocate for the development of evaluation tools and review processes in promoting the quality of the health care services they sponsor.

Most employers have focused these efforts on general health care services. However, there is growing recognition that behavioral health care is in need of even greater attention. Evidence mounts as to the critical impact of behavioral health disorders on employees' overall health and productivity. This *InsightOut* provides an overview of the current trends in behavioral health care and recommends how employers can take the lead in promoting access, quality, and greater integration among all elements of the behavioral health care delivery system. (See *Definitions of Terms* on page 2)

### WHAT EMPLOYERS NEED TO KNOW ABOUT BEHAVIORAL HEALTH

#### Behavioral Health Disorders Are Serious, Common, and Expensive to Treat

The Substance Abuse and Mental Health Services Administration National Survey of 2004 found that 8.2 percent

of fully employed adults presented with a serious mental illness and 10.5 percent were diagnosed with a substance abuse disorder.

In 2001 mental health and substance abuse treatment costs totaled \$104 billion and represented 7.6 percent of total health care spending in the United States. This figure is based on expenditures for all payers, public and private, but does not include the cost of behavioral health care treatment delivered by general medical providers or the cost of psychotropic medications since that comes out of medical coverage.<sup>2</sup> In contrast to other medical conditions, the *indirect* costs (discussed in next section) associated with mental illness and substance abuse disorders commonly meet or exceed the direct costs of treatment.

*The burden of mental illness on health and productivity in the United States and throughout the world has long been profoundly underestimated.*

*U.S. Surgeon General's Report on Mental Health, 1999*

<sup>1</sup> Buck Consultants 2005 National Health Care Strategy Survey

<sup>2</sup> Mark TL. Coffey RM. Vandivort-Warren R. Harwood HJ. King EC. US spending for mental health and substance abuse treatment, 1991-2001. *Health Affairs*, 2005; W5: 133-142

## DEFINITIONS OF TERMS

**Behavioral health care:** Umbrella term referring to a continuum of services available for individuals at risk of, or suffering from, mental, behavioral, and/or addictive disorders.

**Mental illness:** A health condition characterized by alterations in thinking, mood, or behavior mediated by the brain and associated with distress and/or impaired functioning.

**Substance abuse disorder:** A destructive pattern of substance use leading to clinically significant (social, occupational, medical) impairment or distress. For the purposes of this article, substance abuse disorder refers to either substance abuse or substance dependence.

**Depression:** A psychiatric disorder characterized by an inability to concentrate, insomnia, loss of appetite, inability to experience pleasure, feelings of extreme sadness, guilt, helplessness and hopelessness, and thoughts of death.

**Stress:** The “wear and tear” or physical and emotional effects our bodies experience as we adjust to our continually changing environment.

**Psychotropic medication:** Any medication capable of affecting the mind, emotions, and behavior.

**Co-morbid conditions:** Two or more coexisting medical conditions or unrelated disease processes.

**Employer-sponsored behavioral health care services:** Employer-sponsored services that address mental health and/or substance abuse problems. These include services offered through the health plan, disability management programs, EAP, and health promotion or wellness programs.

**Evidence-based behavioral health services:** Services whose effectiveness has been demonstrated.

The landmark HERO (Health Enhancement Research Organization) study published in 1998 determined that health care costs rise when stress and depression are not treated. The survey, based on responses from more than 46,000 employees at several major U.S. companies, found that depression and stress were the primary predictors of total health care costs. Employees who reported that they were unable to control their depression had health care costs 70-percent higher than their non-depressed counterparts. Those who reported being highly stressed experienced health care costs 46-percent higher than their counterparts, who were successfully managing their stress.

## Workplace Costs of Behavioral Health Disorders

Workplace costs of mental illness and substance abuse disorders, otherwise known as indirect costs, include the following: excess turnover; lost productivity; short- and long-term disability; presenteeism and absenteeism. It is estimated that the indirect costs associated with mental illness and substance abuse disorders range from \$79 billion to \$105 billion per year.<sup>3</sup>

Mental illness causes more days of work loss and work impairment than many other chronic conditions such as diabetes, asthma, and arthritis.<sup>4</sup> It is estimated that 217 million days of work are lost annually due to productivity decline

<sup>3</sup> Rice, DP. Miller LS. Health economics and cost implications of anxiety and other mental disorders in the U.S. *British Journal of Psychiatry*. 1998; 173s(34): 4-9.

<sup>4</sup> Kessler RC. Greenberg PE. Mickelson KD. Meneades LM. Wang PS. The effects of chronic medical conditions on work loss and work cutback. *Journal of Occupational and Environmental Medicine*. 2001; 43 (3): 218-225

related to mental illness and substance abuse disorders. This costs employers \$17 billion each year.<sup>5</sup>

A cluster of mental and substance abuse disorders represent the top five causes of disability among people in the age range of 15 to 44 in the United States and Canada. Furthermore, when combined, they are the fifth leading cause of short-term disability and third leading cause of long-term disability for employed adults in the United States.<sup>6</sup>

### **The Current State of Employer-Sponsored Behavioral Health Services**

Most large employers offer medical, behavioral, and pharmacy benefits to their employees. According to the Kaiser Family Foundation Annual Survey, 98 percent of employees covered by employer-sponsored insurance have behavioral health benefits and 99.9 percent have a prescription drug benefit. Additionally, many large employers offer Employee Assistance Programs to their employees.<sup>7</sup>

Employers have been successful in holding specialty behavioral health costs at low and relatively consistent levels over the past eight years. The total cost of behavioral health care has dropped significantly as compared to general medical spending. In part, this drop is the result of employers' strategy of restructuring benefits to further limit inpatient psychiatric hospitalization. Carving out behavioral health has worked in containing costs but it has also created some unintended consequences. Behavioral health providers have become increasingly frustrated with their reimbursement rates after a number of the managed care companies slashed them in the late '90s. Psychiatrists, especially, have bitterly complained and, in some cases, have refused to accept insurance, eventually resigning from networks. In an even more disturbing trend, a number of behavioral health providers remain on the network but do not accept patients covered by plans whose rates are not acceptable to them. Those familiar with the phenomenon call this the "phantom network."

Patients, understandably, have become disenchanted with limits on access to care and the inequality of behavioral health benefits compared to medical services caused by the former's higher deductibles and co-payments.<sup>8</sup>

The delivery of behavioral health care has become increasingly complex and will continue to experience reorganization in response to consumer demands. Currently employer-sponsored behavioral benefits are fragmented, uncoordinated, and uneven in terms of access and quality. One only has to look at the current trends in behavioral health care to understand the need for timely, high-quality, integrated, and evidence-based behavioral health services.

*A significant percentage of patients in primary care show signs of depression, yet up to half go undetected and untreated. This is especially problematic for women, people with a family history of depression ... and those with chronic disease, all of whom are at an increased risk for depression.*

*The President's New Freedom Commission  
Report on Mental Health. 2003*

<sup>5</sup> Hertz RP. and Baker CL. The impact of mental disorders on work. Pfizer Outcomes Research. Publication No P0002981. Pfizer: 2002

<sup>6</sup> 2004 World Health Organization Report

<sup>7</sup> Kaiser Family Foundation. Health Research and Educational Trust. Employer Health Benefits 2004 summary of findings. Employer Health Benefits 2004 Annual Survey. Publication No 7149. Menlo Park, CA: Kaiser Family Foundation; 2005

<sup>8</sup> The Health Care Challenge: Some perspectives from Behavioral Economics; Richard G Frank, Harvard University; Prepared for the Federal Reserve Bank Economic Conference on the Challenge of U.S. Health Reform, June 2005

## FACTS AND FIGURES EMPLOYERS SHOULD NOT IGNORE

### 1. The de-facto mental health care system

A significant proportion of individuals with behavioral health problems are treated exclusively in the general medical setting. Approximately 22.8 percent of individuals treated for a mental illness or substance abuse disorder and 51.6 percent of patients treated for depression receive their care from a general medical provider, such as a primary care physician.<sup>9</sup> Moreover, it is estimated that 11 percent to 36 percent of patients presenting at primary care have a mental illness.<sup>10</sup> In short, the general medical setting has become the “de-facto mental health care system” for many.

Patients have had an incentive to access mental health care from general practitioners because additional financial limitations have not been applied to psychotropic medications and interventions they deliver. However, significant quality concerns are cited in relation to the screening, treatment, and monitoring practices of general practitioners. A disturbing statistic cited in the National Co-morbidity Survey Replication (NCS-R) indicates that only 12.7 percent of individuals treated in the general medical sector received minimally adequate care compared to 43.8 percent of patients treated in the specialty mental health sector.<sup>11</sup> In spite of the prevalence of psychiatric disorders, primary care physicians often do not diagnose them. Even in cases where an appropriate diagnosis is given, the interventions are not always evidence-based and referrals to specialty behavioral health providers are not always completed.

### 2. Psychotropic medications have become the major treatment modality in behavioral health care

The lives of many individuals with mental illness have improved considerably because of prescription medications. Still, when pharmacological intervention is the sole treatment modality, it often does not go far enough in addressing the problems of individuals diagnosed with mental illness. Also, the escalating cost of psychotropic drugs is becoming a concern to employers. By 2001, private employers were spending 17 percent of their total behavioral health expenditures on psychotropic medications.<sup>12</sup>

Current research indicates that the most effective method of treatment for psychiatric disorders is multimodal and combines pharmacological management with psychosocial interventions, such as psychotherapy.<sup>13</sup>

### 3. Co-morbid conditions often go untreated

While employers have focused a great deal of attention on the management of high-cost chronic medical conditions, such efforts have not addressed the significant additional burden of co-morbid mental illness. Research indicates that individuals with chronic medical conditions and untreated co-morbid behavioral health disorders are the most complicated and expensive to treat.

For instance, health care use and health care costs are almost twice as high for patients diagnosed with either heart disease or diabetes with co-morbid depression, even when taking into consideration factors such as age, gender, and other illnesses. The presence of type-2 diabetes nearly doubles the risk of depression and an estimated 28.5 percent of diabetic patients

<sup>9</sup> Kessler RC, Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, Rush JA, Walters EE, Wang PS. The epidemiology of major depressive disorder. *JAMA*, 2003; 289 (23): 3095-3105

<sup>10</sup> American Academy of Family Physicians. Mental Healthcare Services by Family Physicians (position paper). Available online at: <http://www.aafp.org/x6928.xml>.

<sup>11</sup> Wang PS, Lane M, Wells KB, Kessler RC. Twelve month use of mental health services in the U.S.: Results from the National Co-morbidity Survey Replication. *Archives of General Psychiatry*, 2005; 62(6): 629-640

<sup>12</sup> Mark TL, Coffey RM, Vandivort-Warren R, Harwood HJ, King EC. U. S. spending for mental health and substance abuse treatment, 1991-2001. *Health Affairs*, 2005; W5: 133-142

<sup>13</sup> World Health Organization. The World Health Report 2001: Mental Health—New Understanding, New Hope. Geneva, Switzerland: World Health Organization; 2001

meet criteria for clinical depression.<sup>14</sup> One in six patients experiences major depression soon after having survived a heart attack and at least one in three have significant symptoms of depression.<sup>15</sup>

#### **4. Limiting behavioral health care services can increase employers' non-behavioral direct and indirect costs**

The Mental Health Parity Act of 1996 (MHPA) prohibits employers with more than 50 employees from imposing annual or lifetime dollar "caps" on coverage for mental health benefits that are more restrictive than those applied to medical benefits. The parity law, however, does not require a plan to provide mental health benefits. Also, the MHPA allows plans to adopt higher co-payments and deductibles and to impose limits on number of visits or days. The Act does not apply to substance abuse benefits.

Behavioral health experts were concerned that parity in benefit structures would not be meaningful if behavioral health care was managed more tightly than any other types of health care. In fact, their concern seems justified. Experience to date suggests that access to specialty mental health care services has been negatively impacted by such limitations.

One study found that limiting employer-sponsored specialty behavioral health services led to as much as a 37-percent increase in direct medical costs for beneficiaries, who used behavioral health care services. Additionally, limiting behavioral health services led to an increase in number of sick days taken by employees with behavioral health problems. Savings realized by limiting behavioral health benefits were offset by the increased use of other medical services and lost workdays.<sup>16</sup> Based on a year of study, the New Freedom Commission on Mental Health, established in 2002, strongly supports the President's call for federal legislation to provide full parity between insurance coverage for mental health care and for physical health care.

#### **5. The lack of coordination and integration between medical and behavioral health carriers has created significant quality and accountability problems**

Even though the managed care industry has come under increasing pressure from accreditation and regulatory bodies to more fully integrate behavioral and medical delivery systems, evidence clearly indicates that this integration has not occurred. As cited earlier in this article, a large percentage of individuals receive behavioral health services in the primary care setting and co-morbid conditions often go untreated. The President's New Freedom Commission on Mental Health found that a chasm exists between the mental health care and general health care systems. The lack of integration between medical and behavioral health providers has resulted in the inappropriate use of emergency rooms, increased medical costs, and poor consumer service.

On a positive note, Managed Behavioral Health Organizations (MBHOs) recently began to respond to new performance standards from NCQA (National Committee for Quality Assurance) by launching initiatives to promote the coordination of medical and behavioral services. Several of the top MBHOs have initiated quality improvement projects to increase the frequency of communication and promote referrals to behavioral health specialists.

In spite of these efforts, early results suggest that coordination of care between medical and behavioral providers does not regularly occur at this time, even for active shared patients. Several factors seem to be contributing to this lack of coordination. For one thing, carriers and providers often cite their concern over violating the HIPAA (Health Insurance Portability and Accountability Act) privacy rule on the use and disclosure of protected health information (PHI) as a barrier to sharing information.

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<sup>14</sup> Lustman PJ. Clouse RE. Depression in diabetic patients: The relationship between mood and glycemic control. *Journal of Diabetes and Its Complications*, 2005; 19: 113-122

<sup>15</sup> Ziegelstein RC. Depression in patients recovering from a myocardial infarction. *JAMA*, 2001; 286(13): 1621-1627

<sup>16</sup> Rosenheck RA. Druss B. Stolar M. Leslie D. Sledge W. Effect of declining mental health service use on employees of a large corporation: General health costs and sick days went up when mental health spending was cut back at one large self-insured company. *Health Affairs*, 1999; September/October: 193-203

*IBM's Care Advocacy Model generated \$500,000 in savings in 2003. Their model, which was developed by the company's Mental Health Care Program, promotes care coordination for individuals who may have behavioral health problems co-occurring with other medical conditions. It also promotes care coordination across carriers, proactive outreach to prevent illness and integration of medical, behavioral, and pharmacy data.<sup>17</sup>*

Some of the other reasons cited as to why practitioners are slow to respond to directives from health plans regarding collaborative care are: time constraints; lack of financial incentives; complexity in the care delivery system; differences in treatment philosophy and need for control. No matter what is driving this lack of integration, the costs to patients and employers are significant.

## **6. Consumer-Directed Health Plans (CDHPs)**

The move toward CDHPs will continue as employers work on reducing their health care costs by shifting more of the cost and decision-making to their employees. Advocates of

consumerism will point out that by putting economic purchasing power and decision-making in the hands of employees, they become proactive and engaged consumers. Behavioral health experts are concerned that in trying to conserve health benefit dollars, behavioral health issues will either be completely ignored or will be addressed only when they reach a catastrophic level.

Employers give mixed reviews to CDHPs when asked about the impact of their CDHP on cost and quality of care. The EBRI/Commonwealth Fund Consumerism in Health Care Survey, the first national survey of its kind, found that individuals covered by CDHPs were more cost conscious, as predicted, when choosing providers and choosing among treatment options but they were also more likely to avoid, skip, or delay health care because of costs. About 35 percent reported avoiding or delaying care as compared to 17 percent participating in comprehensive health plans.<sup>18</sup>

It is important to note that reduced needed care vs. unnecessary care was not differentiated in this survey. A study by McKinsey & Company in 2005 in which employees enrolled in traditional plans were compared to those in CDHPs found that there is no difference between these two groups in seeking treatment for serious conditions.

There is evidence that those enrolled in CDHPs are more likely to be engaged in health-related activities and behaviors. The Lumenos 2005 Annual Customer Satisfaction Survey indicates that 36 percent of CDHP enrollees vs. 25 percent covered by traditional plans are actively involved in health-related behaviors and 53 percent vs. 42 percent report having increased knowledge in managing their health care. The McKinsey study also found that compared to employees in traditional plans, those in CDHPs are 20 percent more likely to join employer-sponsored wellness programs.

Given that we have limited experience with CDHPs at this point, it is difficult to predict the impact this type of benefit design will have on participants' motivation to access behavioral

<sup>17</sup> "IBM Saves Dollars by Integrating Services." Mental HealthWorks; Second Quarter 2004; American Psychiatric Association and American Psychiatric Foundation; pgs 3-5

<sup>18</sup> Fronstin P. Collins S. Early Experience with High Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. EBRI Issue Brief No. 288; 2005

health services, when needed. Nevertheless, based on the evidence cited earlier in this article regarding the indirect costs of behavioral health disorders, the concern raised by experts over waiting to address behavioral health issues until they become serious should not be ignored.

## 7. The push for quality measurement and improvement

In the past, managed-care organizations paid lip service to outcomes measurement. As regulatory and accrediting bodies establish indicators of quality for health plans, MBHOs are being forced to develop and implement quality improvement projects so that they can report on key quality metrics to all stakeholders.

NCQA is one of several organizations which has developed quality measures for mental health care. By utilizing the Health Plan and Employer Data and Information Set (HEDIS), a set of standardized performance measures, purchasers and consumers can compare the performance of managed care plans. While HEDIS has some limitations, such as, not always accommodating nuances of a particular program, it is generally considered the industry standard for performance measurement.<sup>19</sup>

Health plans are expected to report on following:

- Post-hospitalization follow up by a behavioral health specialty provider within seven days and 30 days after inpatient treatment
- The number of individuals who were diagnosed with a new episode of depression and were treated with an antidepressant
- Whether these individuals received at least three follow-up visits with their primary care physician or behavioral health provider during the 12-week acute treatment phase
- Whether they remained on an antidepressant medication during the entire 12-week acute treatment phase

- Whether they remained on an antidepressant for at least six months
- Timely communication between primary care physician and behavioral health providers

Ensuring continuity of care and providing follow up in the community after inpatient stays for mental illness have been shown to reduce subscribers' health costs and to improve their outcomes of care.<sup>20</sup>

## RECOMMENDATIONS FOR BEHAVIORAL HEALTH PLAN SPONSORS

Employers are justified in their concern over health costs. The evidence is substantial that the direct and indirect costs of behavioral health disorders are significant and need to be addressed in order for employers to achieve a healthier bottom line. Through their sturdy purchasing power, employers are in a very strong position to influence access, delivery, and quality of behavioral health care. The following five recommendations are meant to serve as a guide to employers as they design their behavioral health plans and choose vendors:

- 1. Consider providing full parity in your benefit structures to encourage appropriate utilization of specialty behavioral health services.** Moreover, direct carriers to review new treatment approaches annually and to provide coverage for ones that are evidence-based. Financial incentives for referrals to specialty behavioral health providers could also be included to ensure that subscribers are receiving appropriate care for their behavioral health issues.
- 2. Demand integration and coordination among behavioral and medical providers to fully address co-morbid conditions.** Medical providers, disability, and disease management vendors should be required to screen for depression and other behavioral health disorders among individuals suffering from chronic medical conditions and to coordinate their care with behavioral health providers.

<sup>19</sup> [http://www.hhsc.state.tx.us/Medicaid/reports/082004\\_BHDR.htm](http://www.hhsc.state.tx.us/Medicaid/reports/082004_BHDR.htm)

<sup>20</sup> Fortney J. Sullivan G. Williams K. Jackson C. Morton SC. Koegel P. Measuring continuity of care for clients of public mental health systems. *Health Services Research*. 2003; 38 (4): 1157-1175

**3. Insist on regular reporting of outcome data to ensure that medical and behavioral health providers in the network are providing evidence-based practices.** Because providers are serving anywhere from 10 to 15 different payers that can have different levels of care criteria and quality guidelines, it's important to require carriers to adopt national best practice guidelines. Rewarding providers for adhering to national standards and for meeting established performance criteria should be fully examined by carriers.

**4. Require your vendors to share claims data and report their findings annually.** When vendors share data, they can analyze utilization patterns and address drivers for high and low utilization in a coordinated manner. Employers can also use these annual reports to determine if changes they've made are cost effective.

**5. Work with your vendors to create a plan that addresses treatment gaps and reward them for delivering.** Once the causes of less than optimal utilization are determined, a comprehensive plan, which includes all vendors, should be developed to ensure that access, delivery, and quality are not compromised. Regular screening for depression and stress along with educational activities, appropriate treatment, and follow up are critical components that should be covered by the plan presented to you.

*Health is a complete state of physical, mental, and social well-being and not merely the absence of disease.*

*World Health Organization*

## CONCLUSION

The health care delivery system is quite complex. Determining how to go about providing the highest quality care while controlling costs can be an overwhelming and frustrating task. It is not surprising that employers, patients, and providers have become disenchanted with our current system. Clearly, much work needs to be done on the system level to promote coordination between medical and behavioral care services. By requiring true collaboration between vendors and demanding that evidence-based practices are being followed in treating behavioral health disorders, employers will not only realize savings in their total health costs but will also do "the right thing" for their employees by promoting a holistic approach to maintaining good health.

## ABOUT THE AUTHOR

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